AMENDED IN SENATE JANUARY 6, 2004

AMENDED IN SENATE MARCH 24, 2003

SENATE BILL No. 142

Introduced by Senator Alpert

February 6, 2003

~~An act to add Section 12693.983 to the Insurance Code, and to add Section 14011.65 to the Welfare and Institutions Code, relating to the Healthy Families Program.~~ *An act to amend Section 1357.22 of the Health and Safety Code, to amend Section 10762 of the Insurance Code, and to amend Section 2130 of the Labor Code, relating to health care coverage.*

LEGISLATIVE COUNSEL'S DIGEST

SB 142, as amended, Alpert. ~~Medi-Cal to Healthy Families Accelerated Enrollment Program.~~ *Health care coverage: State Health Purchasing Program.*

Existing law creates the State Health Purchasing Program managed by the Managed Risk Medical Insurance Board. Under existing law, a health care service plan contract with an employer, as defined, and a health insurer selling a policy to an employer that provides health coverage to insureds pursuant to the State Health Purchasing Program requirements, is required to meet specified requirements.

This bill would make nonsubstantive changes to these provisions.

~~Existing law establishes the Healthy Families Program, administered by the Managed Risk Medical Insurance Board, to arrange for the provision of health care, dental, and vision coverage to eligible children meeting certain household income requirements. Existing law authorizes bridge programs which evaluate the eligibility of child~~

~~currently in the program for enrollment in Medi-Cal and bridge programs which evaluate the eligibility of child currently enrolled in Medi-Cal for enrollment in the program. Under existing law, the Healthy Families Program becomes inoperative on January 1, 2004.~~

~~This bill would create the Medi-Cal to Healthy Families Accelerated Enrollment Program that would make children meeting specified criteria eligible for health, dental, and vision coverage under the Healthy Families Program. The bill would require the board to adopt regulations necessary to implement the program. The bill would require the board to submit plan amendments to the federal government that are necessary to ensure full federal financial participation in the program. The bill would require each county to include its costs of implementing the program in its annual Medi-Cal administrative budget request. The bill would provide that the program would be implemented only if federal funding is obtained. Because the bill would place additional requirements on county government agencies, the bill would impose a state-mandated local program.~~

~~The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement, including the creation of a State Mandates Claims Fund to pay the costs of mandates that do not exceed $1,000,000 statewide and other procedures for claims whose statewide costs exceed $1,000,000.~~

~~This bill would provide that, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to these statutory provisions.~~

Vote: majority. Appropriation: no. Fiscal committee: ~~yes~~ *no*. State-mandated local program: ~~yes~~ *no*.

The people of the State of California do enact as follows:

~~SECTION 1. Section 12693.983 is added to the Insurance~~

SECTION 1. Section 1357.22 of the Health and Safety Code is amended to read:

1357.22. On and after January 1, 2006, a health care service plan contract with an employer, as defined in Section 2122.6 of the Labor Code, providing health coverage to enrollees or subscribers shall meet all of the following requirements:

(a) The employer shall be responsible for the cost of health care coverage except as provided in this section.

(b) An employer may require a potential enrollee to pay up to 20 percent of the cost of the coverage, proof of which is provided by the employer in lieu of paying the fee required by Part 8.7 (commencing with Section 2120) of Division 2 of the Labor Code, unless the wages of the potential enrollee are less than 200 percent of the federal poverty guidelines, as specified annually by the United States Department of Health and Human Services. For enrollees making a contribution for family coverage and whose wages are less than 200 percent of the federal poverty guidelines for a family of three, the applicable enrollee contribution shall not exceed 5 percent of wages. For enrollees making a contribution for individual coverage and whose wages are less than 200 percent of the federal poverty guidelines for an individual, the applicable enrollee contribution shall not exceed 5 percent of wages of the individual.

(c) If an employer, as defined in Section 2122.6 of the Labor Code, chooses to purchase more than one means of coverage for potential enrollees and, if applicable, dependents, the employer may require a higher level of contribution from potential enrollees as long as one means of coverage meets the standards of this section.

(d) An employer, as defined in Section 2122.6 of the Labor Code, may purchase health care coverage that includes additional out-of-pocket expenses, such as copayments, coinsurance, or deductibles. In reviewing subscriber or enrollee share-of-premium, deductibles, copayments, and other out-of-pocket costs, the department shall consider those permitted by the board under Part 8.7 (commencing with Section 2120) of Division 2 of the Labor Code.

(e) Notwithstanding subdivision (b), a medium employer may require an enrollee to contribute more than 20 percent of the cost of coverage if both of the following apply:

(1) The coverage provided by the employer includes coverage for dependents.

(2) The employer contributes an amount that exceeds 80 percent of the cost of the coverage for an individual employee.

(f) The contract includes prescription drug coverage with out-of-pocket costs for enrollees consistent with subdivision (d).

SEC. 2. Section 10762 of the Insurance Code is amended to read:

10762. On and after January 1, 2006, a health insurer selling a policy to an employer, as defined in Section 2122.6 of the Labor Code, providing health coverage to insureds pursuant to Part 8.7 (commencing with Section 2120) of Division 2 of the Labor Code, shall meet all of the following requirements:

(a) The employer shall be responsible for the cost of health care coverage except as provided in this section.

(b) An employer may require a potential enrollee to pay up to 20 percent of the cost of the coverage, proof of which is provided by the employer in lieu of paying the fee required by Part 8.7 (commencing with Section 2120) of Division 2 of the Labor Code, unless the wages of the potential enrollee are less than 200 percent of the federal poverty guidelines, as specified annually by the United States Department of Health and Human Services. For enrollees making a contribution for family coverage and whose wages are less than 200 percent of the federal poverty guidelines for a family of three, the applicable enrollee contribution shall not exceed 5 percent of wages. For enrollees making a contribution for individual coverage and whose wages are less than 200 percent of the federal poverty guidelines for an individual, the applicable enrollee contribution shall not exceed 5 percent of wages of the individual.

(c) If an employer, as defined in Section 2122.6 of the Labor Code, chooses to purchase more than one means of coverage for potential enrollees and, if applicable, dependents, the employer may require a higher level of contribution from potential enrollees as long as one means of coverage meets the standards of this section.

(d) An employer, as defined in Section 2122.6 of the Labor Code, may purchase health care coverage that includes additional out-of-pocket expenses, such as copayments, coinsurance, or deductibles. In reviewing enrollee share-of-premium, deductibles, copayments, and other out-of-pocket costs, the department shall consider those permitted by the board under Part 8.7 (commencing with Section 2120) of Division 2 of the Labor Code.

(e) Notwithstanding subdivision (b), a medium employer may require an enrollee to contribute more than 20 percent of the cost of coverage if both of the following apply:

(1) The coverage provided by the employer includes coverage for dependents.

(2) The employer contributes an amount that exceeds 80 percent of the cost of the coverage for an individual employee.

(f) The contract includes prescription drug coverage with out-of-pocket costs for enrollees consistent with subdivision (d).

SEC. 3. Section 2130 of the Labor Code is amended to read:

2130. The State Health Purchasing Program is hereby created. The program shall be managed by the Managed Risk Medical Insurance Board~~, which~~ *that* shall have those powers granted to the board with respect to the Healthy Families Program under Section 12693.21 of the Insurance Code, except that the emergency regulation authority referenced in subdivision (o) of that section shall only be in effect for this program from the effective date of this part until three years after the requirements of this program are in effect for large and medium employers, as provided in Section 2120.1.

~~Code, to read:~~

~~12693.983. The board shall adopt regulations to implement the Medi-Cal to Healthy Families Accelerated Enrollment Program established under Section 14011.65 of the Welfare and Institutions Code. If the board determines that one or more amendments to the State Child Health Plan are necessary to ensure full federal financial participation in the provisions of the program, the board shall prepare and submit requests for the plan amendments to the federal government.~~

~~SEC. 2. Section 14011.65 is added to the Welfare and Institutions Code, to read:~~

~~14011.65. (a) The Medi-Cal to Healthy Families Accelerated Enrollment Program is hereby established to provide any child who meets the criteria set forth in subdivision (b) with temporary health benefits while his or her application is forwarded to the Healthy Families Program established under Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code.~~

~~(b) (1) Any child who meets all of the following requirements shall be eligible for temporary health benefits funded by Title XXI of the Social Security Act, known as the State Children's Health Insurance Program:~~

~~(A) The child, or his or her parent or guardian, either:~~

~~(i) Submits an application for the Medi-Cal Program directly to the county.~~

~~(ii) Has submitted an application for the Medi-Cal Program to single point of entry as defined in subdivision (e) of Section 14011.6, and has been granted accelerated enrollment by the single point of entry pursuant to Section 14011.6.~~

~~(B) The child is not receiving Medi-Cal benefits at the time that the application is submitted, with the exception of accelerated enrollment provided pursuant to Section 14011.6.~~

~~(C) The child is eligible for full-scope Medi-Cal benefits with a share of cost.~~

~~(D) The child is under 19 years of age.~~

~~(E) The child has family income at or below 250 percent of the federal poverty level.~~

~~(F) The child is not otherwise excluded under the definition of a targeted low-income child under subsections (b)(1)(B)(ii), (b)(1)(C), and (b)(2) of Section 2110 of the Social Security Act (42 U.S.C. Secs. 1397jj(b)(1)(B)(ii), 1397jj(b)(1)(C), and 1397jj(b)(2)).~~

~~(G) The child, or his or her parent or guardian, gives or has given consent for the application to be forwarded to the Healthy Families Program.~~

~~(2) The temporary benefits provided under this section shall be effective on the date that the county finds that the child meets all of the criteria in paragraph (1) of subdivision (b) of this section. The benefits shall terminate on the date that the child is discontinued from the state Medical Eligibility Data System due to his or her full enrollment in the Healthy Families Program or ineligibility for the Healthy Families Program.~~

~~(3) The temporary health benefits provided under this section shall be identical to the benefits provided to children who receive full-scope Medi-Cal benefits without a share of cost and shall only be made available through a Medi-Cal provider.~~

~~(c) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department shall, without taking any regulatory action, implement this section by means of all-county letters. The department, in consultation with the Managed Risk Medical Insurance Board and representatives of the local agencies that administer the Medi-Cal program, consumer advocates, and other~~

~~stakeholders, shall develop and distribute the policies and procedures, including any all-county letters, necessary to implement this section.~~

~~(d) If the department determines that one or more state plan amendments are necessary to ensure full federal financial participation in the provisions of this section, the department shall prepare and submit requests for the state plan amendments to the federal government.~~

~~(e) This section shall not be implemented until the later of the date that the state receives approval of all necessary state plan amendments, or six months after this section is enacted.~~

~~(f) Each county shall include its cost of implementing this section in its annual Medi-Cal administrative budget request submitted to the department.~~

~~(g) This section shall be implemented only if, and to the extent that, federal financial participation is available for the services provided. This section shall be implemented in a manner consistent with any federal approval.~~

~~(h) This section shall become inoperative if an unappealable court decision or judgment determines that any of the following apply:~~

~~(1) The provisions of this section are unconstitutional under the United States Constitution or the California Constitution.~~

~~(2) The provisions of this section do not comply with the State Children's Health Insurance Program, as set forth in Title XXI of the Social Security Act.~~

~~SEC. 3. Notwithstanding Section 17610 of the Government Code, if the Commission on State Mandates determines that this act contains costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code. If the statewide cost of the claim for reimbursement does not exceed one million dollars ($1,000,000), reimbursement shall be made from the State Mandates Claims Fund.~~

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